THE

BRITISH JOURNAL

OF

CHILDREN'S DISEASES.

VOL. XIII. JULY, 1916. No. 151.

Original Articles.

HERPES RECURRENS.

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EVERYONE is familiar with the affection known as herpes labialis which frequently accompanies an ordinary cold, and with the similar herpetic eruption which occurs in association with many acute infectious fevers. It is recognised, too, that herpes may attack not only the lip, but also the cheek, the chin, the nostril, or the dorsal surface of the nose, the lobe of the ear, the buccal mucous membranes, or the skin or mucous membranes of the genitals, either in association with an acute infectious fever or with a common cold, or even without other symptoms beyond slight febrile disturbance. All these forms are included under the terms herpes febrilis or herpes recurrens, and are distinct from zona or herpes zoster. J. D. Rolleston has paid particular attention to herpes febrilis in association with acute infectious diseases, and he gives a list of these diseases with the relative frequency of herpes febrilis for each disease.

The list is as follows :—

Lobar pneumonia .	40 per cent.
Malaria . .	
Cerebro-spinal fever .	
Scarlet fever . .	6·5 per cent.

Influenza . . .	6 per cent.
Typhus . . .	5 „
Diphtheria . . .	4·01 „
Typhoid fever . .	1·3–3·5 per cent.
Relapsing fever . .	4 times in 160 cases
Smallpox . . .	2 „ in 3000 „

He adds that it is common in non-diphtheritic angina, and notes the curious fact that an affection with the uniform characters of herpes febrilis should occur with so many different forms of microbic infection. But, as Hebra wrote in 1865, "we are still altogether in the dark as to the relation between herpes facialis (*i. e.* herpes febrilis) and these complaints." From analogy with herpes zoster, in which we find the same type of eruption associated with a lesion of the posterior root ganglia or of nerve trunks, it is supposed the herpes febrilis may depend too upon a nerve disturbance. It seems, however, that such nerve disturbance cannot be due to any specific micro-organism, but, possibly, as Schamberg has suggested, to a hypothetical toxin common to the various infections with which it is associated, which has a special affinity for nerve tissue and particularly for the sensory ganglia. Beyond such speculations we know nothing of the real cause of herpes febrilis.

Weill and Dufourt have recorded two cases of herpes labialis associated with pneumonia in which pneumococci were found in the herpetic vesicles; Rall obtained diphtheria bacilli from the eruption in a case of herpes with diphtheria. But it is not possible to say that the micro-organisms were the cause of the eruption, and it seems more likely that they were an accidental contamination.

In three cases under my own observation of simple herpes recurrens, *i. e.* unassociated with an acute specific fever, films and cultures showed sterile vesicles.

In some cases, especially in cerebro-spinal meningitis, herpes febrilis may be exceptionally severe and extensive, or may have an atypical distribution; but it is not so generally known that herpes recurrens may be severe or may be atypical in distribution in cases unassociated with the acute infectious fevers.

Dubreuilh has recorded examples of recurrent herpes facialis in which a large area of one cheek was involved. Such cases are often mistaken for the rarer examples of herpes zoster of the second division of the fifth nerve, but they are to be distinguished by their tendency to recur and by the absence of subsequent scarring.

Dubreuilh has also described a recurrent herpes of the buttock,

and further examples have been recorded by Sequeira, by Parkes Weber, and by myself.

I published a few years ago a note of some cases of herpes febrilis of the fingers, and cases will be presently mentioned in which the eruption occurred upon the wrist and on the neck respectively.

Herpes facialis.

The following is an example of herpes recurrens of the cheek. The patient was a boy aged 9 years. The eruption had appeared several times a year since he was aged 1½ years, so that he had had already from twenty-five to thirty attacks. He felt poorly before each attack. During the last attack there was a rise of temperature to 101° F., but no other symptoms. The eruptions had left no scars. The boy had adenoids, which have been removed since the last attack, but it is as yet too early to state whether this is going to cure the tendency to the herpetic symptoms.

The following are two cases of marked severity :

Fig. 1 represents the second attack in a boy aged 6 years, who had a similar attack in the same situation seven months previously, after an operation for removal of adenoids. On the second occasion the eruption involved the left side of the face and the lower part of the left side of the nose ; the glands in the neck were enlarged. The temperature was 100·8° F., and four days previously (two days before the eruption appeared) he had vomited several times.

E. L— was a girl aged 15 years, who had had many attacks since she was a baby, generally in the spring, always with a "cold" and always on the left cheek. The present attack was rather more severe than usual, and, in addition to a patch which covered the greater part of the cheek, there was a large patch on the right temple, and the upper and lower lips were involved.

Dubreuilh says of these severe cases of herpes facialis that the eruption always appears for the first time in early childhood, generally at about three or four years of age, but sometimes earlier ; that its duration appears to be indefinite, and that the intervals between attacks vary from one month to one year. The left cheek is affected more often than the right. The eruption recurs always on the same cheek, though it may affect other parts as well in some attacks. The ætiology is obscure, and menstruation as a factor can be excluded by the age and sometimes by the sex of the patients.

Recurrent Herpes of the Gluteal Region.

Dubreuilh collected seven published cases, and to these added another of his own observation. In these cases the eruption began for the first time at the ages of 30, 10, 26, 24, 23, 42, 33, and 41 years, and lasted from two to twenty-five years with outbreaks

Fig. 1.—Herpes facialis.

generally every few months. In some of these cases the patients had previously suffered from recurrent herpes in other more usual situations. A study of the ætiology of these cases brought out the facts that migraine, gout, gravel, and nervous troubles were common, either as personal or as family antecedents, and Dubreuilh concluded that herpes glutealis is a manifestation of latent or declared gout.

In 1911 I published in the 'British Journal of Dermatology' the case of herpes of the buttock illustrated in Fig. 2, and also three

other cases which had been under the care of Dr. Sequeira, who kindly gave me his notes.

The patient, L. R— (Fig. 2), was a boy, aged 7 years. The eruption consisted of a large herpetiform group of vesicles covering almost the whole of the right buttock, in a patch which measured 9 to 10 cm. in diameter. The eruption had appeared without any accompanying pain. The boy had had several attacks of herpes on the lips, and twice before a similar less extensive eruption on the

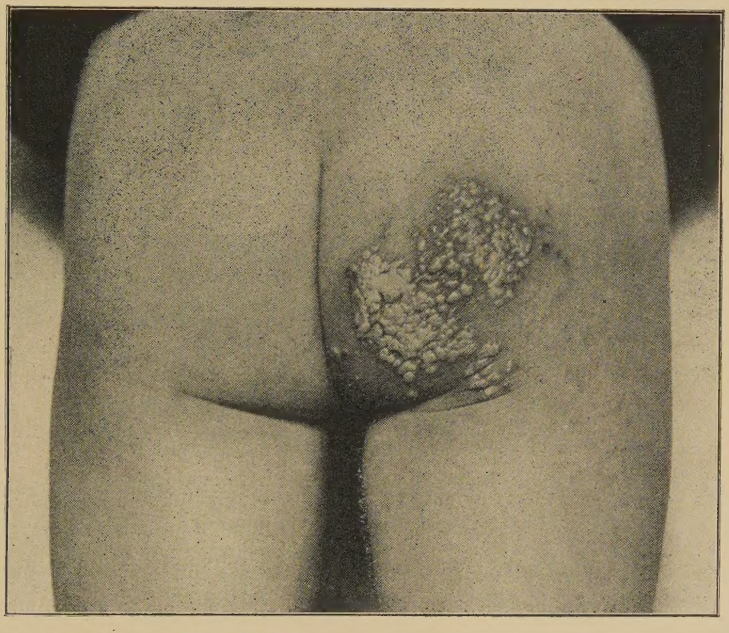

Fig. 2.—Herpes recurrens glutealis.

right buttock. The temperature was normal, and the boy otherwise healthy.

Dr. Sequeira's cases were a young lady aged 24 years, a married woman aged 28 years, and a professional man aged 40 years. In the first case the eruption was a small patch on the left buttock, and had recurred during the past two years with nearly every menstruation. In the second case the eruption was also on the left buttock, and not more than five or six vesicles. The eruption had occurred irregularly before menstruation during three years. In Case 3, the eruption had recurred two or three times a year for two years. His father and his father's family were gouty. Parkes Weber, in a discussion on "Dermatitis Herpetiformis" at a meeting of the Derma-

tological Section of the Royal Society of Medicine, recalled three cases of women aged 44, 57, and 63 years, who had attacks of herpes-like clusters on the gluteal region, and regarded these (wrongly, I think) as possibly minor forms of dermatitis herpetiformis.

In my own experience I have been unable to trace any connection between herpes recurrens and gout, or, indeed, any affection other than a common cold, and in all cases of recurrent herpes in an unusual situation apparently beginning in adult life I have been able to get a history of herpes labialis from childhood. I have no data as to the prognosis in these cases, but it would be interesting and important to know whether children eventually lose the tendency to these attacks. Sequeira mentions a case of herpes facialis in which

Fig. 3.—Herpes recurrens in digitalis.

the attacks ceased after removal of adenoids, but in two of my cases the first outbreak of the eruption followed an operation for adenoids.

Recurrent Herpes in other Situations.

As examples of recurrent herpes in situations quite away from mucous membranes I may mention some cases of herpes on the finger or thumb in infants and young children, of which I published a note in the 'British Journal of Dermatology' in 1909. Fig. 3 is such a case. Figs. 4 and 5 illustrate recurrent herpes, in one patient on the neck, in another on the wrists. In each instance there had been many recurrences upon the same area.

I know of no cure for these troublesome eruptions. One ought to remove or remedy any source of reflex irritation such as adenoids, dental trouble, eyesight defects, and intestinal worms in the case of

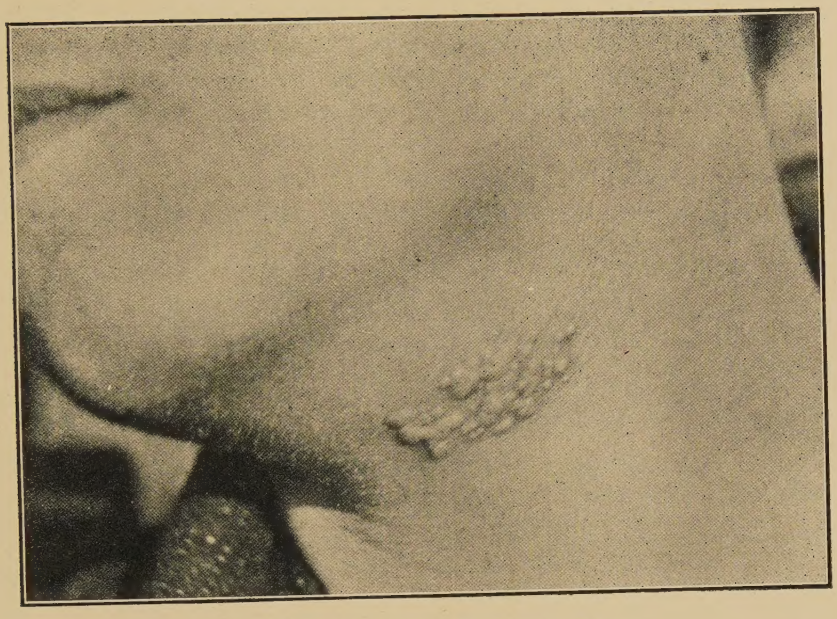

FIG. 4.—Recurrent herpes of neck.

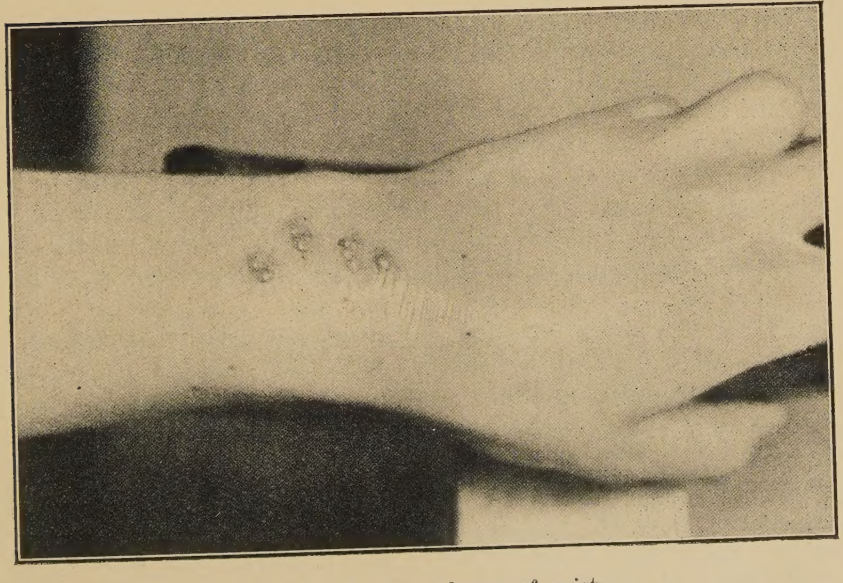

FIG. 5.—Recurrent herpes of wrist.

herpes of the buttock. It has seemed to me that a dose of quinine (2–5 gr.) at the beginning of an attack will sometimes abort it, as also the local application of collodion before the vesicles have matured, or of calamine lotion if they have already formed.

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A CASE OF ATELEIOSIS.

By F. PARKES WEBER, M.D., F.R.C.P., and G. F. STEBBING, M.B., B.S.

ATELEIOSIS is the name given by Hastings Gilford to a kind of general and symmetrical dwarfism and infantilism, due to more or less complete bodily and mental arrest of growth and development. The dwarfism of ateleiosis is not mainly confined to the limbs (micromelia), as in achondroplasia, nor to the head, as in microcephalic idiots, nor to certain glandular or other viscera, as in cases of hypoplasia of the sexual organs (without general infantilism), or of the heart and large arteries; but it affects the whole body, trunk and limbs (microsomia).

Ateleiotic dwarfs differ from each other according to the period at which relative or absolute arrest of growth and development has occurred, that is to say, according to the stage of growth and development reached before more or less complete arrest took place. A good index of the stage of bodily development is furnished by skiagrams of the various long bones, especially of the hands and feet, showing persistence of epiphysial cartilages, etc.

Owing to long practice and continual experience in the simple matters of everyday life and in work requiring little skill or manual dexterity, an ateleiotic's mental development on superficial examination may appear to be considerably more advanced than it really is. In 1913 one of us published an account of two cases of ateleiosis * in which Dr. Reginald Langdon-Down kindly examined the patient's mental development by the Binet tests. One case was that of a woman, aged 20 years, but whose ossification and general development corresponded rather to that of a girl aged 12 years. Dr. Langdon-Down estimated her intellectual development as equivalent to that reached by the average child of about 13 or 14 years of age. The other case was that of a man, aged 45 years, but whose ossification and general development corresponded rather to that of a boy aged 9 years. Dr. Langdon-Down estimated his intellectual development as equivalent to that reached by the average child of 8 years of age. His head was rather large for the diminutive size of his body. The shape of his trunk, the undeveloped state of his sexual organs, the appearance of his neck (owing to the want of projection of the "pomum Adami"), and the high pitch of his voice were those of a child; but his expression, the wrinkles on his face, his attitude, his manner of speaking and his general behaviour were somewhat more like those of an adult. His mental condition was childish, but otherwise not abnormal. He could not read or write, but he earned a little money by light work in a glass factory. Dr. Langdon-Down, in his report, wrote: "The patient is interesting, as he was deliberately deprived of school instruction on medical advice, and, on the other hand, owing to his mature years, has long been subject to the influences of everyday life in town. The result of this environment has been to produce a superficial sharpness in one or two directions which might readily mislead one in judging of his intellectual development." In regard to the above-mentioned female ateleiotic, who was able to earn a little money at fur-machining, Dr. Langdon-Down remarked: "It is obvious that social status and

* F. Parkes Weber, "Two Cases of Ateleiosis' British Journal of Children's Diseases, 1913, x, pp. 346–353.

environment may exercise considerable influence in these higher levels, and that standardisation becomes more difficult, owing to increasing complexity of development and individual divergencies."

That the occurrence of ateleiosis is of *endocrinic* origin, that is to say, due to some defect in the internal secretions of endocrine glands, is, of course, highly probable ; but more data are required in this respect, as well as general increase in our knowledge regarding the action and interaction of the various endocrinic

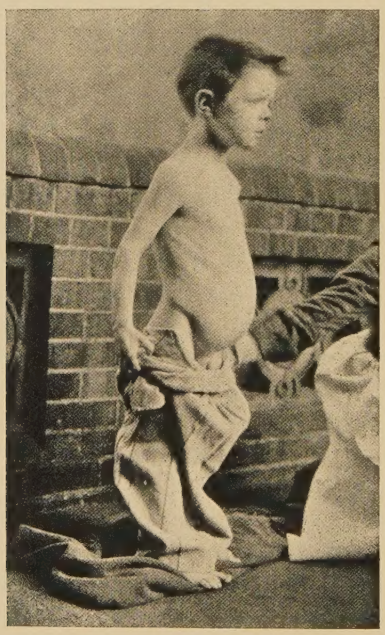


Fig. 1.

organs of the body. The sexual glands are naturally more or less hypoplastic and defective in ateleiotics. In both the above-mentioned cases the thyroid gland seemed to be of abnormally small size. In the description of the male patient it was stated : " The texture of the skin, the facial complexion, the extreme fineness of the hairs of the scalp, and the small size of his thyroid gland, all suggest that there may be an element of hypothyroidism combined with the ateleiosis, but these features may be merely a part of the general infantilism." In regard to the condition of the pituitary gland in these cases we believe that very little is known, excepting that Roentgen-ray skiagrams of the base of the skull seem to show

that the pituitary fossa is usually rather small than large. In the above-mentioned female case skiagraphic examination made it probable that the pituitary fossa was rather small, as it almost certainly also was in the male case.

Our present patient is a boy, Herbert A. D—, aged 16 years, whose size is not greater than that of the average child of 5 or 6 years. He was admitted to the Lambeth Infirmary on February the 9th, 1916. At that time his height was 43 ins. (109¼ cm.) and his weight was 48½ lbs. (22 kilograms). His prominent abdomen (Fig. 1) and relatively rather large head conform to the infantile type of proportions. He is physically strong and is able to run and walk normally, though he is habitually very slow in his movements and in conversation. There is no evidence of any thoracic or abdominal visceral disease; certainly no cardiac abnormality nor enlargement of the spleen or liver is present. The thyroid gland cannot be felt. The generative organs appear to be at the stage of development usual in a boy of about 4 or 5 years. There is no pubic, axillary or facial hair. The urine, when tested, was of specific gravity 1020, acid, and free from albumin and sugar. There is no pollakiuria nor apparently any polyuria. The patient has not to get up to micturate at night-time; there is no nocturnal enuresis nor any diurnal incontinence of urine. The pupils react to light and accommodation, and all his reflexes appear to be normal. There are no signs of rickets, nor do the various Roentgen skiagrams show the changes usually found in rickets. The patient has a snub-nose, with a sunken bridge, but he has no adenoid vegetations of the naso-pharynx, and there is no evidence of congenital (inherited) syphilis. The stage of ossification in his bones, as illustrated by the Roentgen-ray photographs of his hands (Fig. 2) and his feet (Fig. 3), corresponds roughly to that in a normal boy of 4 to 5 years old. The pituitary fossa, as seen in the skiagram (Fig. 4) of the base of the patient's skull, appears to be rather large than small, in relation to the small size of the whole body. As regards his tolerance for sugar, a daily dose of 3 ozs. of sugar, given for several days, produced no glycosuria.

The mother first noticed something wrong with the boy when he was 4 years old. He was then mentally backward. At present, as already stated, he is habitually very slow in his movements and in conversation. He has never been able to say his alphabet and he cannot read or write or do the simplest arithmetic, such as adding two figures together. He is able, however, to draw objects that can be recognised on a slate. He seems to know the value of money,

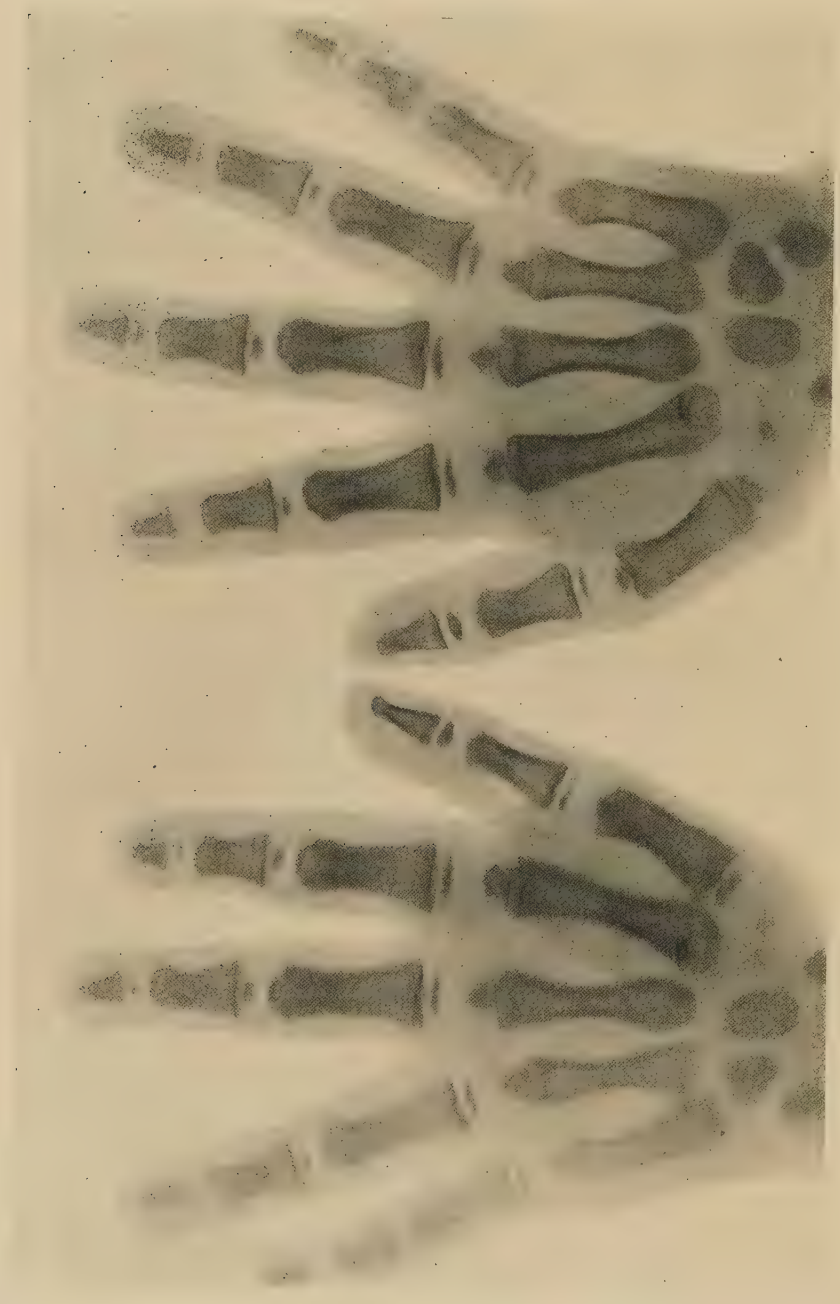


Fig. 2.

and whether the right amount of change has been given him when he buys anything. He has a certain amount of cunning; for

Fig. 3.

instance, he asked once for a clay pipe to blow bubbles and was given a penny to buy one. He seemed to appreciate the value of what he got, and asked several other persons for a clay pipe, expecting the same result.

According to the mother, the patient is the eldest of a family of

seven children. Of the remaining six, one died in infancy of pertussis; all the others are living and healthy and apparently normal, excepting one "who is a cripple and has a short leg from some unknown cause." The mother is not aware of the existence of any similar disease in either her own or the father's family.

The patient has been treated at several hospitals and has been to

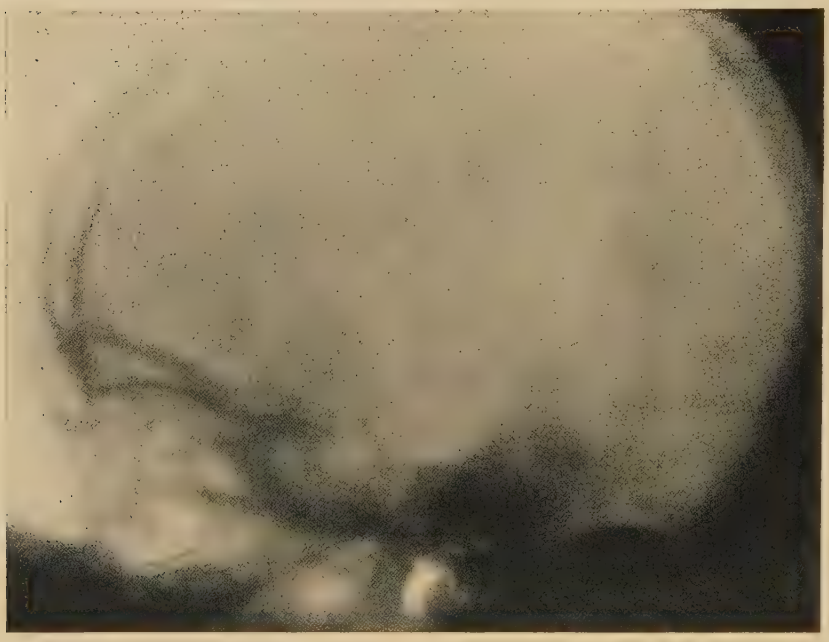


Fig. 4.

a special school. The mother thinks he has grown a little during the last year. Since admission to the Infirmary he has been given thyroid treatment for six weeks, without any resulting improvement; in fact, the treatment seemed to make him mentally worse. His mother thinks that he has gained a little in intelligence during the last month, which coincides with a period during which he has been treated with dried pituitary substance. No really decided change has, however, been produced.

APPENDICITIS COMPLICATING PNEUMONIA.

By J. Allan, M.D., D.P.H.

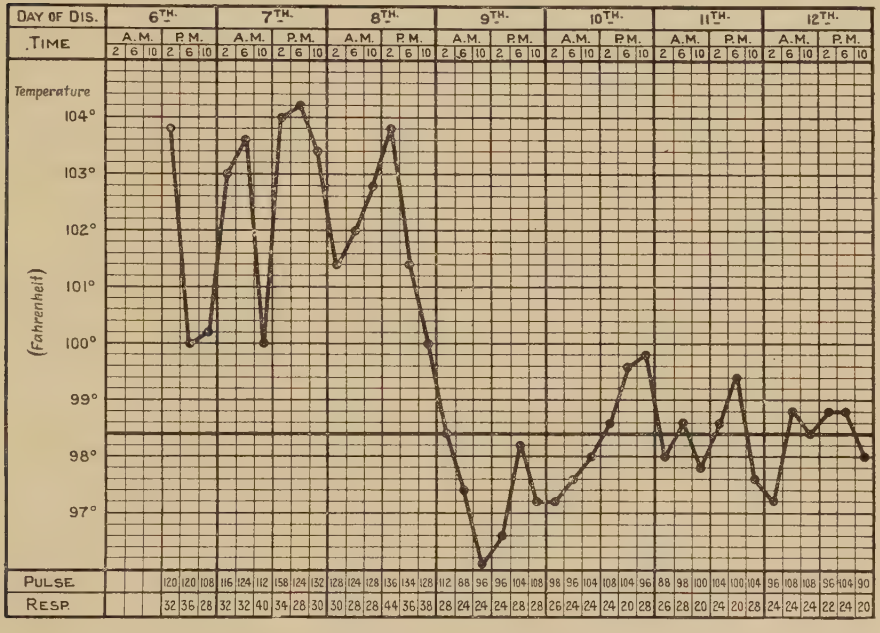
Appendicitis in children is more common than is generally supposed, and it is not unlikely that many of the so-called gastric attacks, frequently met with in children, are really appendicular in nature. Acute appendicitis at this period of life is a very serious and dangerous affection, and it is practically universally admitted that early operation is the best treatment. The case whose clinical history I am about to relate presents several features of interest, which can be better discussed after the various facts have been duly recorded.

A girl, aged 11 years, was admitted to hospital with acute abdominal symptoms, the medical man in attendance having made a diagnosis of acute appendicitis. The illness began six days before with sickness and vomiting, the child feeling out of sorts but not acutely ill. No history of indiscretion of diet was obtained. Two days before admission abdominal symptoms supervened. She complained of some abdominal pain, which was not very definitely localised, but which tended to be more severe in the right lower quadrant of the abdomen. The medical man in attendance reported that there had been marked tenderness over the appendix region during the twenty-four hours preceding admission. There had been no sickness or vomiting except during the initial stage of the illness, as already noted. The bowels had been somewhat loose, and once or twice slime had been noticed in the stools. The child had been running a temperature, and on the morning of the day of admission this reached 105·2° F. During the previous night she had been delirious. There was no history of cough, and no pain in the chest had been complained of. All symptoms were abdominal. On admission her condition was as follows : The child had an anxious expression, but there was no cyanosis, and the breathing, though a little rapid, was in no way distressed. She complained of acute abdominal pain, and when asked to indicate the spot of greatest severity pointed to the right iliac region. Inspection was negative, there being no limitation of movement noticeable at any one part. On palpation there was general abdominal tenderness, but over the appendix area this was certainly more evident, and the abdominal muscles in that region were distinctly on guard. Very marked tenderness was elicited on pressure over McBurney's point.

Percussion did not reveal anything of importance. The temperature was 103·8° F.; pulse rate 120; respirations 32. There was no sickness or vomiting. The urine was acid in reaction, rather concentrated, and showed a faint cloud of albumin. The child did not cough, and on examination of the lungs nothing abnormal was noted. The other systems were apparently healthy. All the signs and symptoms, subjective and objective, appeared to mirror an acute abdomen, and it was decided to explore the appendix region. This was done and the appendix was removed. The appendix was found inflamed, and on opening it blood-clot was discovered inside. The vessels in the appendix wall were thrombosed, and there were several thread-worms lying within the cavity of the organ. There was no ulceration of the appendicular wall, but the appearance gave one the impression of progressive inflammatory mischief rather than of subsidence of the inflammatory trouble. No other intra-abdominal organ was found implicated at the time of operation. It may be mentioned that anæsthetisation was carried out by a chloroform and ether mixture (C_1E_2), and no difficulty was experienced as regards its exhibition either during the period of induction or during the maintenance of the anæsthesia. Just after the operation the temperature registered 100° F., but at 6 a.m. on the following morning it reached 103·6° F. The child had a fairly comfortable night after the operation and slept a little at intervals, but she was delirious at times. On the day after the operation a very troublesome cough developed, apparently for the first time since the commencement of the illness. Breathing was a little more distressed, though the rate of respiration had not markedly increased. The lungs were carefully examined and signs of consolidation were discovered at each base, but on neither side was the area of consolidation very extensive. However, some impairment of the percussion note over the areas in question, with slight increase of vocal resonance and the presence of fine crepitations at the bases, seemed to suggest pneumonia. After events amply justified this conclusion. The child remained in a more or less delirious condition, the temperature curve kept high, never falling below 100° F., the breathing was laboured, and there was cyanosis at times. At 2 p.m. on the second day—that is to say exactly forty-eight hours after admission, the temperature was 103·8° F.; pulse rate 136; respirations 44. Thereafter the temperature fell steadily until 10 a.m. on the following day, when it was 96° F. The temperature curve is shown in the accompanying diagram. The patient had, in fact, a typical and unmistakable crisis, which occurred on the

eighth day of the disease. Thereafter progress was rapid, and after an uneventful convalescence the child was discharged cured, just over three weeks after the operation, the abdominal wound having healed by primary union.

Here we have an example of appendicitis complicating pneumonia. There are cases in which lobar pneumonia may develop without the



Four-hourly temperature chart of case of J. D—, aged 11 years.

usual physical signs, and may so closely simulate appendicitis that it is diagnosed as the latter condition ; but on abdominal section inflammatory changes in the appendix are conspicuous by their absence. The case just recorded does not quite fall within this category, for in this case the appendix was undoubtedly inflamed and definite pathological changes had taken place in its walls. Whether the inflammation would have subsided if expectant treatment had been adopted it is impossible to say, but my impression from an examination of the organ after removal was that the inflammatory trouble was progressive, not retrogressive. If the case had been left in all probability ulceration would have occurred in the appendix, with perhaps gangrene and perforation, and an operation would have been imperative later, and in very much more unfavourable circum-

stances. I have no doubt that in this case we had a secondary pneumococcal infection of the appendix following on an atypical pneumonia; atypical in so far as physical signs were absent until late in the disease. It is in such atypical cases that it is so difficult to differentiate between lobar pneumonia and appendicitis in children, although one generally finds that it is during the first day or two of the disease that such mistakes are likely to arise. It should be remembered that pneumococcal infection of the lungs may exist for days without the occurrence of demonstrable physical signs, and in not a few cases the infection may run its entire course without going on to consolidation. It may be asked if there are no points for differential diagnosis between these two conditions, and it must be admitted that one has to rely more on general data than on specific differential diagnostic tests. It is well when approaching a possible case of appendicitis in a child to bear in mind the possibility of lung infection, and it would be a good plan to examine the chest thoroughly and repeatedly in all such cases. This is especially true if cough is present. Some pædiatric clinicians believe that prolonged expiration is an early sign in pneumococcic infection of the lung, but this cannot be relied on. The relation of the temperature curve to the pulse and respiration rates should be carefully examined. Perhaps the examination of the urine for the diminution or disappearance of the chlorides might help, as some observers consider the absence of, or marked dimunition in, the chlorides in the urine to be almost pathognomonic of pneumonia. All facts should be carefully weighed, and these are cases in which consultation between the physician and the surgeon should prove invaluable. Whatever be done no doubt mistakes will occur, and perchance the enthusiastic surgeon may open the abdomen for inflammation of the appendix (when that organ is not at fault) during the progress of a lobar pneumonia. In my opinion the opportune surgeon is less worthy of condemnation than the expectant physician. In the one case the patient may be submitted to an unnecessary operation, no doubt a truly regrettable incident, but on the other hand delay may allow of perforation to take place, and the resulting peritonitis may compel operative interference when it is too late. Even if recovery takes place, the prolonged and tedious convalescence after operation for septic peritonitis, and also the undermining of the patient's health, are, to my mind, strong points in favour of early operation. The "wait and see" policy is, in my opinion, dangerous, and I should feel much inclined to say, "when in doubt, operate." If one may judge from the present case, the exhibition of an anæsthetic in the presence of

pneumococcal infection of the lungs is not fraught with much extra danger. In submitting such cases to careful and judicious consideration, one must not overlook the fact that the two conditions may co-exist, as in the case I have just quoted. It seems to me that while the treatment of appendicitis in children by early operation is pretty generally admitted, there still remains much to be done from the point of view of diagnosis, which is by no means perfect. This offers a field for further painstaking and assiduous investigation and study, and all points which tend towards the elucidation of this important problem, viz. the perfecting of the early diagnosis of appendicitis, should receive at the hands of the medical profession most careful examination, and should command the attention of all scientific workers in this branch of medicine.

Royal Society of Medicine.

OTOLOGICAL SECTION.

November the 19th, 1915.

Bony Sequestrum, believed to be the Annulus Tympanicus, removed from the External Meatus of an Infant, aged 2 years 9 months.—Mr. H. L. Whale.—The child had suffered continuously from otorrhœa since the age of 14 months.

Keratosis of the Auditory Meatus.—Mr. W. Stuart-Low.—The patient was a girl, aged 8 years, who had had a discharge from the left ear for over a year. Two months ago white spots began to appear at the lowest and outermost part of the meatus; these gradually coalesced and spread round the passage, forming a tough white ring. Dr. Wyatt Wingrave had examined specimens under the microscope, and described it as an irritative keratosis, similar to what was not uncommonly met with on the tonsils, and said to be due to the presence of a leptothrix. He thought any true parasitic growth could be completely excluded in this case.

Cartilaginous Overgrowth after the Radical Mastoid Operation.—Mr. W. M. Mollison.—The patient, aged 15 years, had suffered from chronic otorrhœa for years, and had had several operations. Two years ago a radical mastoid operation was performed on the left ear. A few months later a cartilaginous nodule had appeared at the concho-meatal junction, and had grown to its present size slowly. Suppuration had continued in spite of operation, and now the mass of cartilage was obstructing the meatus.

Case of Audible Tinnitus.—Mr. W. M. Mollison.—The patient, a boy, aged 9 years, complained of a "ticking" in his ears; his mother noted that she could hear the noise herself. There was an easily audible ticking in the

left ear, very clearly heard through an otoscope; it was not synchronous with the pulse, and was much less audible when the boy's mouth was open. A similar noise was to be heard in the right ear, but much less loud. The boy had retracted membranes, and large tonsils and adenoids. The noise was presumably due to irregular contractions of the tensor tympani.

Note.—February the 16th. Since the last meeting the boy had had his tonsils and adenoids removed, but the tinnitus continued. His tubes had been inflated without any alteration in the tinnitus.

DERMATOLOGICAL SECTION.

December the 16th, 1915.

Recurrent Herpes Zoster of the Face with Hemiatrophy.—Mr. Wilfred Trotter.—The patient was a girl, aged 11 years, with a history of repeated attacks of herpes on the right side of the face since infancy. The attacks began when she was aged 1 year, and had recurred every two or three months since; each attack was preceded by headache and fever, but local pain was not a marked feature. All attacks previous to the present one had involved only the second division of the fifth cranial nerve, the lesions being limited to the centre of the right cheek and right side of the nose. In this present attack, however, the lesions present were two in number, distributed over the areas of the buccal and submental branches of the third division of the fifth nerve. Two other points were of interest: first, very marked pitted scarring was present at the site of previous lesions; and, secondly, there was marked atrophy of the cheek on the affected side. There were no appreciable sensory changes in the skin of the face.

The child had had measles, chicken-pox, and scarlet fever, but otherwise had been in good health. There was no history of tuberculosis or syphilis in the family. The mother had had thirteen other children, who were all alive and well, and had had no miscarriages. There was no evidence of any disease—no enlargement of tonsils, no adenoids, and no ear trouble; the teeth and mouth were in good condition and the child had never had any eye trouble.

Cases of this type were of interest from two points of view: first as to ætiology, and, secondly, as to nomenclature. In this case the evidence appeared to point to the lesions being in the region of the Gasserian ganglion and of an inflammatory nature. As regards nomenclature, Mr. Trotter believed the case to be a true zoster, and that it differed entirely from the cases of recurrent, irregularly bilateral herpes which occurred around the mouth. The case was sent to him as possibly due to some intracranial trouble.

Case of Morphœo-sclerodermia with recent acute symmetrical involvement of the Soles of the Feet.—Dr. George Pernet showed a girl, aged 14 years, who was first seen at the West London Hospital on July the 31st, 1914, for morphœic manifestations on the outer side of the right thigh, quite typical, but with a very diffuse lilac discoloration extending for some distance around (instead of the usual ring). Thickening followed, and the sclerodermia had progressed on the limbs in a symmetrical manner. She was now brought forward again on account of an acute symmetrical involvement of both soles, which was observed on November the 12th last. The affected areas were at that time pale, and somewhat swollen and œdematous, with a well-defined purple-lilac border. They were very tender and painful to

pressure. There was some hyperidrosis of the feet. Since then the pain on pressure had subsided to a great extent, and so had the swollen condition, giving place to a certain amount of toughness of the parts.

Dr. Pernet considered the condition of the soles was part and parcel of the morphœo-sclerodermic process. The patient had been on small doses of thyroid on and off since she was first seen, but the sclerodermia had advanced notwithstanding.

Philadelphia Pediatric Society.

February the 8th, 1916. Dr. John F. Sinclair, President.

Dr. Charles Macfie Campbell, of Johns Hopkins, delivered the annual Packard lecture.

He said that the intensive work done during the last twenty years on the functional nervous disorders of the adult had brought about a marked change of attitude in dealing with them. There was less inclination to attribute these disorders to hypothetical intoxications, nor was a mere reference to the basis of constitutional psychopathic inferiority sufficient; the aim was now to find the meaning of each disorder, and its *rôle* in the adaptation of the individual to the environment.

The unembarassed study of the real biological unit led beneath the surface to other dynamic factors, to more elemental but deeply rooted forces which it was usual to ignore.

Neurotic symptoms to a large extent found their explanation in these underlying trends, and among the determining factors of the symptoms a prominent place must be given to the attitudes, the problems, and the conflicts of childhood.

The child might have an unsuspected complexity of forces determining his behaviour. The recognition of this complexity helped to the understanding of some of the nervous manifestations of childhood, which otherwise would be unintelligible. The child's life at an early age might show indications of conflicts which tradition only admitted in the adult.

It might seem rather revolutionary to allow to a child of tender years an emotional life of such complexity.

In the treatment it was important to recognise the real factors involved and not to be satisfied with vague hypotheses as to toxic processes or with references to constitutional instability.

In speaking of the neurotic utilisation of symptoms, Dr. Campbell said that symptoms might arise in various ways; they might be the result of present compromise, or expression of a nervous instability which needed no special conflict to elicit them, or they might even be the product of some casual somatic disorder; once they had arisen they might serve a certain function, and be made use of for the adaptation of the individual to the environment.

Among the gastric symptoms presented by neurotic children vomiting was not uncommon, and in some cases this symptom formed a very serviceable help to the child for the attainment of his ends.

Headache was another symptom which the child found easily at his disposal in the face of unpleasant situations.

Of the nervous manifestations of childhood none were more alarming than the various attacks which were liable to occur. The diagnosis of epilepsy was often difficult, and it was well to keep in mind the possibility that an attack, even though presenting some of the features of an epileptic equivalent, might really form part of a subtle mechanism by which the child attained a desired goal.

The fact that a symptom in some cases might be utilised in a certain way or might indicate certain conflicts did not justify the conclusion in all cases that it was so utilised and must always indicate such conflicts.

In the origin of neurotic symptoms in general one must depend on the researches of the pædiatrist, employing biochemical and physiological methods.

The pædiatrist, by the application of accurate methods to the study of these early symptoms, might contribute to psychopathology a much clearer formulation of the basis of some types of nervous constitutions.

Abstracts from Current Literature.

Diseases of the Respiratory System.

Statistical study of respiratory diseases as a factor in the causation of infantile mortality (*'Am. Journ. Obst.,'* 1916, LXXIII, *p.* 362). —**W. C. Woodward.**—In the registration area of the United States in 1913 respiratory diseases caused 15·85 per cent. of the total mortality in the first year of life. As a factor in infantile mortality this group was exceeded in importance only by pathological conditions peculiar to infancy (33·16 per cent.) and diseases of the digestive system (27·12 per cent.). The mortality for respiratory diseases in the first year of life constituted approximately a quarter of the total mortality from these diseases at all age periods taken together. Bronchitis and pneumonia together caused 96 per cent. of all deaths in the first year due to respiratory diseases. The percentage of infantile mortality in individual states and cities ranged from 10·87 per cent. to 22·83 per cent. Deaths from respiratory diseases occur to a greater extent during the third week of life than during any other weekly period.

J. D. Rolleston.

The prevention of respiratory disease in early life (*'Arch. of Ped.,'* 1916, XXXIII, *p.* 81).—**R. S. Haynes.**—Dust and smoke and overcrowding should be avoided as much as possible. Early care of children suffering from pertussis or measles and careful isolation of contacts should be insisted upon, and careful disposal of the discharges at the mouth, throat, and nose in those already sick. The room in which anyone has been ill with respiratory trouble should be thoroughly cleansed with soap and water, sunlight, and fresh air. Good food and warm clothing are essential, and waterproof material in wet weather. Cold sponging helps to harden children. Adenoids and enlarged tonsils should be removed and constipation avoided. The teeth should receive attention and a mouthwash is often desirable.

F. R. B. Atkinson.

Removal of an open safety-pin, point up, from the left bronchus (*'Cleveland Med. Journ.,'* 1915, xiv, *p.* 517).—A boy, aged 7 years, inhaled an open safety-pin. He was seized with a paroxysmal cough, and became cyanotic. X rays showed an open safety-pin in the trachea just below the larynx. The next day, under suspension laryngoscopy, the pin could not be seen in its position on the plate, but after use of the bronchoscope its position was located at the bifurcation of the trachea. The following day tracheotomy was performed under ether, and the pin was removed by using a Killian tube. The patient was able to leave the hospital on the fourth day

J. D. Rolleston.

Partial atelectasis with capillary bronchitis and a temperature of 110° F. (*'Amer. Journ. Obst.,'* 1916, lxxiii, *p.* 372).—**A. Hymanson.** A first child of healthy parents was born at full term on May 1. It was born asphyxiated, and remained so for two hours, but was finally resuscitated. During the first day of life its temperature rose to 102° F., and on the third day to 105° F. During the next fortnight it fluctuated between 98° and 103° F., and respirations were from 40 to 70. Expiration was hardly audible at the base and apex of the lungs, and there were scattered *râles* in the chest. On July 30, when one month old, the baby was in a convulsive state. The rectal temperature, taken by three different thermometers, was from 109·6° to 110° F. A colon irrigation, at a temperature of 85° F. gradually cooled to 65° F., was given for six minutes; the radial arteries and head were rubbed with ice, and finally a bath was given at a temperature of 85° F., gradually cooled to 70° F., and brandy and aromatic spirits of ammonia were administered. The temperature slowly dropped to 99° F., and gradual improvement took place, but three weeks later the pulmonary signs became worse, enteritis developed, and death took place on August 23.

J. D. Rolleston.

Septic bronchitis, pleurisy, and pneumonia treated by inoculations suggested by direct hæmolysis (*'Lancet,'* 1915, ii, *p.* 279).—**A. Cassels Brown** saw the patient, a boy aged 10 years, for what appeared to be a septic tonsillitis. The history given was that he had caught a cold on his way home from school two days previously. There were a quickened pulse, a slightly elevated evening temperature, and a good deal of hard cough, with some muco-purulent expectoration. On auscultation there was a certain amount of bronchial catarrh noticeable, which more particularly affected the right lung. There were also slight enlargement and tenderness of the cervical glands on both sides. He was treated by various antiseptic applications to the throat and given a mild febrifuge and expectorant mixture. No improvement followed, and it was found that the scattered exudations on the tonsils had coalesced, giving an appearance uncommonly like diphtheria. A swab from the throat was sent for examination and diphtheria antitoxin (2000 units) was given, this dose being repeated on the following day. Next day the exudation had disappeared. The report of the throat swab was negative for diphtheria bacilli. The boy's condition seemed worse, and a patch of broncho-pneumonia was now noted at the base of the right lung. The purulent expectoration had very much increased by this time, and the bronchial tubes at the base, especially of the right lung, were dilated and choked with secretion. The case was seen in consultation, a diagnosis of septic bronchitis, broncho-pneumonia, and pleurisy was made, and vaccine therapy was thought advisable. A tube of blood

was taken and sent to Dr. Lyon Smith, who sent an antigen, 1 c.c., of which contained sensitised strepto bacilli 20 millions, sensitised staphylococci 100 millions, bacillus coli 5 millions, micrococcus catarrhalis 10 millions, sensitised pneumococci 30 millions, bacillus septus 20 millions. The injection of 0·1 c.c. was followed in thirty-six hours by a very marked reaction, the temperature mounting suddenly to 104·6° F. This rise of temperature was accompanied by the most copious expectoration and a certain amount of fluttering of the pulse. The patient was ordered ½ oz. of port wine every four hours and was given frequent inhalations of oxygen. He was also sponged down with tepid water. Two days after the first injection he was given a similar injection with similar results. Two days later an injection of half the dose was given, and there was no reaction, delayed or otherwise, and the patient was beginning to look and feel much better. This treatment was persevered in, and after a long and tedious convalescence recovery has taken place. H. Lyon Smith discusses direct hæmolysis: a test for bacterial toxins and for estimation of dosage in vaccine therapy.

J. Allan.

The diagnostic significance of D'Espine's sign (*'Am. Journ. Dis. Child.,'* 1915, x, *p.* 183).—**H. F. Stoll.**—D'Espine's sign, or whispered bronchophony in the interscapular space first described by him in 1907 as diagnostic of enlargement of the bronchial glands, is best elicited when the arms are folded well across the chest, with the head strongly flexed and the patient sitting erect. Firm pressure should be made with the stethoscope as the patient repeats "three thirty-three." Young children may be made to say the word "tree." The enlargement of the glands may be due to malignancy, leukæmia, Hodgkin's disease, syphilis, or any infectious disease of the lungs. The presence of the sign in the delicate child is exceedingly suggestive of tuberculous involvement of the tracheo-bronchial glands (*cf.* British Journal of Children's Diseases, 1913, x, p. 179).

J. D. Rolleston.

Asthma in children: its relation to "egg-poisoning" (*'Boston Med. and Surg. Journ.,'* 1914, clxxi, *p.* 708).—**F. B. Talbot** records six cases in children aged from 5 to 8 years to prove that asthma is a manifestation of anaphylaxis, *i. e.* a local manifestation in the lungs. In a certain number of children asthma may be due to egg-poisoning (*vide* British Journal of Children's Diseases, 1913, x, *p.* 228). Scarification of the skin and inoculation with egg-white shows whether egg albumin is the specific cause of the asthma. Many, if not all, cases of egg asthma may be immuned to egg-white by feeding them with gradually increasing doses of egg albumin in capsules.

J. D. Rolleston.

Large pin in the lung removed by operation (*'Riv. di clin. pediat.,'* 1915, xiii, *p.* 9).—**M. Fiorini** and **F. Rossi** report the case of a girl, aged 8 years, who had "swallowed" a pin five years previously and had since suffered from recurrent attacks of broncho-pneumonia, constant irritating cough with purulent and sometimes fœtid expectoration. There were no tubercle bacilli present. Radioscopy showed a large pin, 7 cm. long, in the left lower lobe. Resection of 6 cm. of the eighth and ninth ribs posteriorly between the vertebræ and posterior axillary line was performed under chloroform in a sitting posture. The pleura not being adherent the wound was plugged with iodoform gauze and perfect adhesion obtained after eight days. Pneumotomy was then performed under slight narcosis in a sitting posture, the thermo-cautery being first used and then exploration

with the finger, which reached a purulent cavity and felt the head of the pin, which was extracted with a calculus forceps, the remainder of the pin, about 4 cm., was expelled in two pieces by cough. The patient left her bed on the eighth day, cicatrisation of wound being completed in three months, leaving her in a state of florid health. VINCENT DICKINSON.

Can pneumonia in children be aborted? (*'New York State Journ. Med.,'* 1915, xv, *p.* 445).—**T. W. Clarke** answers this question in the affirmative, and gives his experiences with hexamethyleneamine employed for this purpose. He has found that the temperature begins to fall within a few hours of the starting of the drug, and in from twenty-four to forty-eight hours the patient has been well. In giving the drug, care must be taken that it is given in plenty of water or milk, and that as much water as possible is taken besides. Even with the greatest care one will at times get strangury or slight hæmaturia. When this occurs it has been his custom to discontinue the drug and give sodium bicarbonate, and, beyond a few hours' discomfort, no untoward effects have been noted. In cases where empyema has developed the drug seems to have little or no effect.

J. ALLAN.

Preliminary report on pneumonia in children, with special reference to its epidemiology (*'Amer. Journ. Med. Sci.,'* 1916, CLI, *p.* 14).—**G. R. Pisek** and **M. C. Pease.**—The paper is based on a study of 1000 cases of lobar and broncho-pneumonia admitted to the Babies' Ward of the New York Post-Graduate Hospital in the last nine years. The children were all under 6 years of age. The mortality was 34·3 per cent. Lobar pneumonia is much more frequent in the first two years of life than is commonly supposed, and is always due to the pneumococcus, while a broncho-pneumonia may be due to a variety of organisms, such as the streptococcus or *B. influenzæ*, occurring alone or as a mixed infection. If pneumococci are present in broncho-pneumonia they are usually one of a group of various organisms, or at least are of low virulence. The pneumococcus may be divided into four general groups (*vide* BRITISH JOURNAL OF CHILDREN'S DISEASES, 1915, XII, p. 80), each being made up of many races which are closely related. This division is of the greatest importance from the standpoint of treatment. J. D. ROLLESTON.

The diagnosis of pneumonia (*'Clin Journ.,'* 1915, XLIV, *p.* 297).—**J. A. Lindsay.**—Pneumonia in the young child often presents the following features: (*a*) The onset is often characterised by the absence of an initial rigor, and by the presence of headache, vomiting, convulsions, and often by "meningism." (*b*) The course of the temperature is often irregular. (*c*) Sputum is usually absent. (*d*) Pleuritic pain is often slight. (*e*) The physical signs in the chest are often obscure. (*f*) The subjective sense of dyspnœa is less than in the adult, while the respirations are often more frequent. (*g*) The course of the case is often irregular and atypical.

J. D. ROLLESTON.

Friedländer's pneumonia; recovery (*'Interstate Med. Journ.,'* 1915, XXII, *p.* 1133).—**C. H. Dunn** reports the case of an infant, aged 14½ months, who was the subject of lobar pneumonia. The chest was twice explored for empyema, but on both occasions the needle entered the lung and no fluid was found. A little fibrinous material was withdrawn, which on each occasion gave a pure culture of a gram-negative capsulated bacillus. The child made a good recovery. Very few cases of Friedländer's pneumonia have

been recorded in children, and none, so far as the writer is aware, in infants. It is generally regarded as a fatal form of the disease.

T. R. Whipham.

Foreign body pneumonias (*'Arch. of Ped.,'* 1915, xxxii, *p.* 881).—**A. Caille** records three cases with skiagrams. Case 1.—Boy, aged 2 years and 10 months, who had been ill for four weeks with chills, fever, vomiting, cough and dyspnœa. The blood showed a moderate leucocytosis and increase of the polymorphs. There was dulness over the entire right lung posteriorly and in the right axilla. The breath sounds and voice were indistinct at the base, aspiration was negative. The spasmodic character of the cough, the expectoration of pus in an acute lesion in the absence of the amphoric breathing characteristic of a cavity, suggested a foreign body. A skiagram of the right lung showed a large tack, which was removed by the aid of the bronchoscope after it had been in the lung about five weeks. Case 2.—Girl, aged 2 years. Pneumonia one year ago. There was no resolution after the attack, but a spasmodic cough persisted. The right lung was found to be solid. A skiagram showed a large nail in the left bronchus and partly in the trachea. Attempts to remove the nail with the aid of the bronchoscope failed until a low tracheotomy had been done. Death took place from extensive pneumonia three days later. The nail had probably been in the lung for over a year. Case 3.—Boy, aged 4 years. Three days before admission he was said to have swallowed a shawl pin. On admission the lungs were normal, and there was no cough. A skiagram showed the pin in the left bronchus and lung. An attempt to remove it with the aid of the bronchoscope failed, and for two weeks the child had irregular fever. The day before the one fixed for a second operation the child had a severe spasmodic coughing spell and coughed up a brass shawl pin $2\frac{1}{2}$ in. long, which had been in the lung forty-three days without causing local inflammation. Caille concludes that (1) all cases of unresolved pneumonia and cases of atypical pneumonia should be X rayed; (2) all foreign body cases should be reported in the lay press as a warning to those in charge of children to keep things out of their reach.

J. D. Rolleston.

Influenza and grippe in infants and children (*'Med. Record,'* 1916, lxxxix, *p.* 226).—**C. G. Leo-Wolf** considers there are two distinct entities, the latter embracing what are called colds. The former is caused by Pfeiffer's bacillus, the latter by numerous organs not the bacillus. A description of influenza is given and compared with the symptoms of "grippy colds." Special attention is drawn to the complication of otitis media in grippy infections. In the treatment of the latter in rhinitis the author relies on instillations of argyrol and also of adrenalin. In bronchitis and laryngitis he recommends compresses and packs and the bronchitis kettle. No drugs are given internally except to resist complications.

F. R. B. Atkinson.

Broncho-pneumonia in scarlet fever (*'Thèses de Paris,'* 1914–15, No. 89).—**M. Besse.**—Broncho-pneumonia is not rare in scarlet fever. It occurs in malignant cases in young children, especially in those with chronic lesions of the larynx or bronchi. It may develop at any stage of the disease. It is frequently associated with purulent pleurisy. The prognosis is bad. In three-quarters of the cases it is fatal. The younger the case the higher the mortality. The thesis contains the history of 27 cases, 25 in children aged from 5 months to 8 years, and 2 in adults. Twenty-two died and 5 recovered.

J. D. Rolleston.

Respiratory complications of scarlet fever (*'Thèses de Paris*, 1914–15, *No.* 80).—**M. Toupance.**—These are much less rare than the text-books state. Severe *laryngitis* due to streptococci occurs in 5 per cent. In young children, in whom it is most frequent, it causes superficial but extensive lesions and is almost always fatal. After 7 years of age the lesions are more limited and deeper. Recovery may take place either spontaneously or after operation. *Bronchitis*, which occurs in from 2 to 6 per cent., is the commonest and mildest respiratory complication of scarlet fever. When it occurs at an early stage it forms part of the scarlatinal eruption; at a later stage it sometimes heralds a relapse, but it should always suggest the onset of measles. *Broncho-pneumonia* is seen in from 1 to 2½ per cent. of all cases of scarlet fever. It usually occurs in hospitals and in young children with a severe infection of the naso-pharynx. It may follow bronchitis, or be of septicæmic origin. The streptococcus is the causal agent. About half the cases are fatal. *Pneumonia* occurs in less than 1 per cent. It may mark the onset of scarlet fever, and the two diseases may run their course without any effect on each other. Relapses of scarlet fever, however, are more frequent in such cases. When pneumonia occurs during the period of eruption or desquamation, it tends to affect the apex of the lung and often assumes a torpid form which is all the more difficult to recognise, as a pleural effusion frequently accompanies it. Pneumonia is a grave complication and is fatal in about 60 per cent. The later it occurs the more serious it is. The streptococcus is the usual micro-organism present. The pneumococcus is rarely found, and only in late cases. *Pleurisy* occurs in about 0·8 per cent. of scarlet fever cases. In only one-third of the cases does it remain sero-fibrinous (*vide* British Journal of Children's Diseases, 1909, vi, *p.* 133). *Purulent pleurisy* assumes several clinical forms, viz. typical generalised empyema following pneumonia, a torpid form, a latent form in young children suffering from broncho-pneumonia and interlobar pleurisy, but all are characterised by the rapidity of the pus formation, the abundance of the effusion, and the gravity of the general condition. The prognosis is grave; the mortality is about 40 per cent. The causal agent is usually the streptococcus in *sero-fibrinous pleurisy*. The effusion may be associated with a focus of pulmonary engorgement or result from propagation from adjacent pericardial lesions, or, lastly, be of tuberculous origin. There is no antagonism between scarlet fever and tuberculosis. Scarlet fever may sometimes have no action on tuberculosis, or, on the other hand, light up old tuberculous lesions and cause a generalised tuberculous infection, especially in young children. In exceptional cases an old tuberculosis may react on scarlet fever by means of chronic hepatic lesions of tuberculous origin. Scarlet fever then assumes a malignant and rapidly fatal course. J. D. Rolleston.

Case of broncho-pneumonia complicated by hemiplegia (*'Lancet,'* 1915, ii, *p.* 285).—**V. M. Métivier.**—The patient, a girl, aged 1¾ years, had conjunctivitis and a cough, but there were no signs in the chest. Two days later there were marked signs of bronchitis, and towards the evening of the following day symptoms and signs of broncho-pneumonia were present. The illness proved a severe one, and ten days after the commencement the left arm and leg were found to be paralysed, and the reflexes on that side of the body were increased. The child made a good recovery, in spite of an attack of measles, which retarded the improvement of the lung condition. The hemiplegic symptoms are clearing up well. The cause of the hemi-

plegia was most likely cerebral thrombosis. Many factors were at work to produce it. The cerebral circulation must have been very much hampered when the illness was at its worst. Owing to the destruction of very large numbers of leucocytes, fibrin-forming bodies would be set free in large numbers. The patient was being fed chiefly on milk, which contains a fair percentage of calcium. The endothelium of the small vessels was liable to be damaged by circulating toxins. The author has found that small frequent doses of ammonium carbonate and tincture of belladonna are invaluable in bronchopneumonia, in lobar pneumonia in children and babies, and in pneumonia complicating pertussis. These two drugs are well tolerated by babies and young children. They act primarily as respiratory stimulants. Nux vomica is apt to cause convulsions if given in doses large enough to help respiratory and cardiac mechanisms. Ipecacuanha is useful in the very early stages. It should be avoided generally when there are definite signs and symptoms of pneumonia. Potassium iodide and ammonium chloride are most effective in getting the bronchitis to clear up and the consolidation to resolve.

J. Allan.

Accidental pneumothorax during tracheotomy, with report of a case (*'Ann. of Otology,'* 1915, xxiv, *p.* 303).—**S. Iglauer.**—This accident is rare. The author's case was a male child, aged 23 months. A diagnosis of foreign body in the air-passages was made, and, the child being cyanosed, a low tracheotomy was done without an anæsthetic. The child struggled continuously and pneumothorax of the right side resulted. Under careful treatment the child recovered, the lung having re-expanded by the twenty-seventh day. No foreign body was discovered, the real cause of the trouble probably being acute subglottic laryngitis. Macleod Yearsley.

Clinical notes on the radiography of the thorax in children (*'Edin. Med. Journ.,'* 1915, ii, *p.* 326).—**J. S. Fowler** considers that the value of radiography in the clinical diagnosis of lung disease in children is probably not sufficiently widely recognised. He places great reliance on it, and does not now feel justified in forming a positive conclusion in a doubtful case, even when the ordinary physical signs are absent, without an X-ray examination. For various reasons screening is unsatisfactory in children; a radiograph should be made, and the appearance compared with the physical signs. As a rule the changes seen in the plates agree with, or at least do not contradict, the physical signs. Frequently they are more marked than the signs lead one to anticipate; the reverse of this—marked physical signs with few radiographic findings—is much more rare. The author gives the clinical histories of several cases to illustrate the usefulness of this method of diagnosis, and groups them under the headings (1) miliary tuberculosis of the lungs; (2) pleural exudates. J. Allan.

The value of the X ray in intra-thoracic lesions in children (*'Arch. of Ped.,'* 1915, xxxiii, *p.* 891).—**R. G. Freeman.**—The X ray is probably most valuable in the diagnosis of miliary tuberculosis, in determining a pneumonia without physical signs, in the diagnosis between pneumonia and empyema, and in the diagnosis of diaphragmatic hernia, while in heart lesions it gives reliable information as to enlargement, and will often differentiate plastic exudation from fluid. Freeman records three cases, illustrated by skiagrams, in which X rays were of service,

viz. central pneumonia, endocarditis and pericarditis with effusion, and enlargement of the heart due to mitral disease.

J. D. Rolleston.

The Roentgen ray in the diagnosis of pulmonary conditions in children (*'Am. Journ. Dis. Child.,'* 1915, ix, *p.* 405).—**W. M. Hartshorn** records eight cases illustrated with skiagrams in children aged from 7 months to 10 years, and one in a woman, aged 40 years. His conclusions are as follows: (1) X rays are of distinct value in the diagnosis of respiratory diseases. In pneumonia a shadow may appear over the suspected area several days before the development of definite physical signs. (2) They are of value in showing the progress of lung involvement. (3) X rays help in the differential diagnosis between tuberculosis, abscess of the lung, lobar and broncho-pneumonia. (4) Through the obliteration of the costal-phrenic angle, the X rays show the presence of an exudate. J. D. Rolleston.

Traumatic asphyxia (*'Lancet,'* 1915, ii, *p.* 911).—**W. W. Linington** describes an interesting case of traumatic asphyxia in a girl, aged 11 years, and makes brief references to other recorded cases. The pathology of these cases is purely mechanical: paralysis of the veins, venules, and capillaries due to over-distension. The only factors determining the area affected are: (*a*) The absence of venous valves sufficiently strong to prevent the reversal of blood flow; and (*b*) the amount of support afforded by the surrounding tissues to the valveless veins. The actual cause of the cyanosis is the sluggish circulation. In the condition under consideration the dilatation of the veins to several times their normal extent without any corresponding arterial enlargement means that the blood stream becomes sluggish and the tissues extract from the hæmoglobin all the oxygen, causing the extreme discolouration which only disappears when the vein has returned to its normal calibre and the current of blood its normal rate of flow. An excellent coloured plate illustrates the patient's condition on the second and sixth days. J. Allan.

A case of polyorrhomenitis (*'Lancet,'* 1915, ii, *p.* 177).—**W. A. B Young**.—A male infant, aged 2 years, came under observation for a cough and weakness following an attack of measles. The patient had well-marked rickets; he was pale, in very poor condition, and had a distressing cough, with some shortness of breath. The physical signs in the chest were slight dulness at the right base, with impaired resonance at the left root behind, and generalised rhonchi and moist *râles* on both sides. The case was treated as one of rickets with broncho-pneumonia, probably of a tuberculous nature. The signs persisted almost without alteration until death. The post-mortem findings are given in detail, but it is of interest to note that a detailed search failed to reveal in any part of the body any lesion similar to those usually associated with tuberculosis. The condition of the glands was of interest. The deep cervical glands showed considerable and uniform enlargement, those along the sheath of the great vessels of the neck being fused into a more or less homogeneous mass. The glands were pale in colour and firm in consistence: to the knife they felt tough and fibrous and did not cut easily, but there was no evidence of caseation. The mediastinal glands were also much increased in size and had the same dense matted appearance, the right pretracheo-bronchial and right interbronchial groups being most affected. They were also firm and tough. The abdominal glands were affected in a similar manner, but only to a comparatively slight degree. As

much of the three great gland groups as possible was removed from the neck, the mediastinum and the mesentery, and subsequently examined histologically and bacteriologically, each group being examined separately. Cut sections, stained in the usual way, showed considerable thickening of the gland capsule and very marked infiltration of the gland substance with fibrous tissue, but there could be found no tendency to the formation of tubercles, and epithelioid cells could not be identified. Tubercle bacilli were not found in the sections. Smears from the cut surfaces of the glands and from the mixed juice and pulp of the crushed glands failed to show tubercle bacilli. Inoculation of an emulsion of the crushed glands into guinea-pigs was positive for tubercle. An interesting clinical feature of the case was that the history of the sequence of measles, pneumonia and tuberculosis was found in this atypical case, just as it is so often noticed in cases with typical post-mortem tuberculous lesions. J. ALLAN.

Dermatology.

Creeping eruption (larva migrans) of the skin (*'Journ. Amer. Med. Assoc.,'* 1916, LXVI, *p.* 172).—**F. C. Knowles** reports the case of a female infant, aged 20 months, who presented serpiginous gyrating lines on both buttocks and the upper surface of the mons Veneris caused by burrows of the larva migrans. Attempts to destroy the parasites with nitric acid having failed, the affected areas were excised. The histological changes set up are discussed and drawings of sections of the skin are appended.

T. R. WHIPHAM.

Generalised erythrodermia desquamativa (*' Arch de Méd. des Enf.,'* 1915, XVIII, *p.* 629).—**Mlle. Loewe** records six cases in new-born infants of this condition which was first described by Leiner in 1908 (*vide* BRITISH JOURNAL OF CHILDREN'S DISEASES, 1908, V, *p.* 244), and is characterised by a bright uniform redness of the skin followed by intense desquamation, and accompanied by seborrhœa of the scalp. The new-born and young infants are chiefly affected. Almost always they are the offspring of healthy parents, and are born at full term after a normal pregnancy. Four of the six cases were breast-fed. There is no fever or digestive disturbance. Erythema first appears on the buttocks, then extends to the lower limbs and trunk, and becomes generalised. Four of the six cases recovered, two were lost sight of. Contrary to the view held by German and Austrian writers the affection seems to be relatively mild, and, like eczema, to be due to an auto-intoxication of alimentary origin. Treatment consists in rest, suitable diet, suppression of baths, and use of dry dressings with talc.

J. D. ROLLESTON.

Infantile eczema (*'New York Med. Journ.,'* 1915, CII, *p.* 704).—**H. W. Cheney** says infantile eczema is mainly a nutritional disorder and may be the only external evidence of a disordered metabolism. There is usually no marked upset in digestion such as is manifested by vomiting and diarrhœa; it is only when the cases are studied closely that we find most of them are due to *overfeeding,* either with all food or with excess of sugar or fat. In treatment, external applications ought not to be considered first but after a careful examination of the food. If breast-fed, the infant may be fed irregularly and too frequently with an over-supply of rich milk. The mother should take more exercise and less milk, cream, and cereals, and

feeding should be at longer intervals—giving an ounce or two of water or barley water before breast-feeding. For the bottle-fed baby the amount of fat may be lessened and perhaps also the carbohydrate or sugar. Some cases resist this and can often be cured by using the albumin milk of Finkelstein, which rids the milk of its salts. The skin may be cleansed by cold cream or sweet oil and protected from scratching. Bland antiseptic ointments are useful. One contains starch, zinc oxide, and boric acid in petroleum. J. Porter Parkinson.

Impetigo nephritis (*'Deutsch. Arch. f. klin. Med.,'* 1916, cxviii, *p.* 462). —**H. Eichhorst.**—Four children in one family, aged from 2 to 14 years, contracted impetigo contagiosa. Two developed severe nephritis, one slight albuminuria, and one died of uræmia. No bacteriological examination was made, as the cases were not seen until a late stage. Eichhorst thinks that the occurrence of nephritis in all the members of the family was due to the feeble resistance of their kidneys to the toxines derived from the septic infection of the skin (*cf.* British Journal of Children's Diseases, 1911, viii, *p.* 85, and 1913, x, *p.* 321). J. D. Rolleston.

Psoriasis in a young child (*'Dublin Journ. Med. Sci.,'* 1916, i, *p.* 134). —**C. M. O'Brien,** at a meeting of the Royal Academy of Medicine in Ireland, Section of Medicine, showed a case of psoriasis in a child, aged $2\frac{1}{2}$ years, whose mother and grandmother had suffered from the disease. He emphasised the rarity of psoriasis before the age of five years and also the distinct heredity. The eruption, which was dry, scaly, and papular, involved the knees, elbows, arms, legs, and backs of hands. The chest and scalp were quite free. He had in mind the possibility of the case being one of seborrhœic eczema, but had come to the conclusion that the eruption was psoriasis. J. Allan.

Linear nævus (*'Lancet,'* 1916, i, *p.* 246).—**W. K. Sibley,** at a meeting of the London Dermatological Society, showed a child, aged 3 years, with linear nævus which had been successfully treated with salicylic acid and creosote, 15 per cent. J. Allan.

Granuloma annulare (*'Lancet,'* 1915, ii, *p.* 1252).—**Graham Little,** at a meeting of the Royal Society of Medicine, Section of Dermatology, showed a case of granuloma annulare in a young girl. The lesions were on the backs of the legs. There was a strong family history of tuberculosis, but the child showed no evidence. The lesions frequently disappeared spontaneously, and but rarely appeared on the face. J. Allan.

The Simpson light in lupus (*'Lancet,'* 1916, i, *p.* 76).—**W. D. Harmer** and **E. P. Cumberbatch,** in a valuable paper on its nature, mode of production, and application, report the case of a child, aged 5 years, who had a patch of lupus on the right leg, not ulcerated, measuring 2 in. by 2 in. Thirty-one exposures to the Simpson light (open arc) were given over a period of fifteen weeks. The length of exposure was gradually increased till, at the end of eleven weeks, its duration was seven minutes. It was then gradually diminished to three minutes. The whole area of skin, with the exception of a patch $\frac{1}{4}$ in. in diameter, had healed. It was slightly pigmented. The patient had previously received local medicinal treatment, but without avail. At the time of reporting the patient was still under treatment. J. Allan.

Mongolian blue spots at São Paulo (*'Arch. de Méd. des Enf.,'* 1915, xviii, *p.* 544).—C. **Ferreira.**—During 1914, 513 infants attended the infants' dispensary at São Paulo, and were classified as follows: Whites, 493; mulattos, 20; negroes, 10. The Mongolian blue spots were present in 6, or 1·1 per cent. of the whites; in 10, or 50 per cent. of the mulattos; and in 5, or 50 per cent. of the negroes, as compared with 33 per cent. met with in 1913 (*vide* British Journal of Children's Diseases, 1915, xii, *p.* 251). J. D. Rolleston.

Trichokyptomania (*'Journ. Amer. Med. Assoc.,'* 1916, lxvi, *p.* 185).—**R. L. Sutton** describes a case of this neurodermatosis which is allied to dermatothlasia and trichotillomania (*vide* British Journal of Children's Diseases, 1915, xii, p. 312). The patient was a girl, aged 18 years, who presented a peculiar, irregular, patchy type of baldness, which at first only involved the eyebrows and lashes, but later extended also to the parietal and post-auricular regions. She at first disclaimed all responsibility for the condition, but later confessed to the habit of twisting one or two hairs at a time and breaking them off with her nails. Under a course of psychotherapy appreciable progress towards recovery has been made in a few weeks.
T. R. Whipham.

Review.

The Medical Annual: A Year-book of Treatment and Practitioner's Index, 1916. Thirty-fourth year. Bristol: John Wright & Sons, Ltd. Price 10s. net.

A large number of articles in the present volume are concerned with the medicine and surgery of the war, such as "frostbite," "insanity and the war," "poisoning from gas," "shell shock," "soldier's heart," and the articles on injuries of the ears, eyes, and bones in war.

The papers on "The Medical Officer and the Fighting Man, by Deputy Surg.-Gen. A. Gascogne, Wildey, R.N., and on "Wound Infections: their Bacteriology, Biology, and Treatment," by Dr. A. C. Inman, deserve special attention. The subject of children's diseases receives the same careful treatment that it has had in previous issues. With the exception of acute infectious diseases, which are summarised by Dr. E. W. Goodall, the medical diseases of children are dealt with by Dr. F. Langmead. Other articles of pædiatric interest are those on congenital malformation of the heart and rheumatic heart disease by Dr. Carey Coombs, on otitis media and tuberculosis of the ear by Dr. J. S. Fraser, on poliomyelitis by Dr. J. Ramsay Hunt, on thyroid insufficiency by Dr. H. French, and on vulvo-vaginitis by Dr. C. F. Marshall. Articles relating to the surgery of childhood are contributed by Mr. W. I. de Courcy Wheeler, and Dr. Graham Little writes on various diseases of the skin occurring in children.

The following recent original articles in this Journal receive notice: The atonic form of cerebral diplegia, the oculo-cardiac reflex, pneumococcus infection and immunity, the sex distribution of rickets, the vaccine treatment of scarlet fever, and the treatment of chronic lymphoid leukæmia with benzol. J. D. R.